

North Central London Sector Joint Health Overview and Scrutiny Committee

4 October 2013

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held at Haringey Civic Centre on 4 October 2013

Present

Councillors

Gideon Bull (Chair)
Arjun Mittra
Graham Old
John Bryant (Vice Chair)
Alev Cazimoglu
Anne-Marie Pearce
Dave Winskill
Martin Klute

Borough

LB Haringey
LB Barnet
LB Barnet
LB Camden
LB Enfield
LB Enfield
LB Haringey
LB Islington

1. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Cornelius, Rawlings (Cllr Mittra deputising) and Kaseki.

Members of the Committee expressed disappointment at the late postponement of the visit to the 111 service and requested that a new date be identified before the end of October. In particular, this would enable it to feed into work that was being done by Camden's health overview and scrutiny committee on out-of-hours care. Members also requested that papers for future Committee meetings be made available in advance of the meeting and in one tranche.

In respect of the agenda item on Cancer and Cardiovascular Service Reconfigurations, the Chair reported that this item had been deferred. This was because NHS England had not been able to approve the case for change in time for the meeting. A meeting had taken place recently with the Chairs of all three joint health overview and scrutiny committees (JHOSCS) covering north and north east London with officers from the Commissioning Support Unit, who were leading on the issue on behalf of NHS England. It had been reported at the meeting that it was likely that a full public consultation would be required. There was a statutory requirement for a joint committee of all the local authorities affected to be set up but it had been agreed that consultation, in the first instance, would be through the existing JHOSCs. A larger joint committee of all boroughs affected would be set up in the meantime and this would meet at the end of the process to agree a composite response.

2. DECLARATIONS OF INTEREST

Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda.

3. URGENT BUSINESS

None.

4. MINUTES

RESOLVED

That the minutes of the meeting of 19 July be agreed as a correct record.

5. MOORFIELDS EYE HOSPITAL

John Pelly, the Chief Executive of Moorfields Eye Hospital reported on the services provided by Moorfields as well as information on its proposed re-location. Moorfields was the oldest established eye hospital in the world. It treated a wide range of eye conditions, including both routine and rare conditions. Just over half of the hospital's activity took place on its City Road site with the remainder taking place in 19 different locations in and around London. In some locations, their services supplemented the work of other hospitals whilst elsewhere Moorfields ran the full range of ophthalmic services. They were also a world renowned centre of research and a teaching centre for undergraduate doctors and other professionals.

The site in City Road was now very old with the Children's Centre being the only new part. The Board had therefore decided to relocate and the Kings Cross/Euston area was considered to be the best potential option for the hospital to re-locate to. There were currently a number of options within the area that were being considered.

The Vice Chair reported that the NHS organisations had previously not always followed through their interest with the developer in the Kings Cross central area and this could possibly influence the developers' attitude to Moorfields. Mr Pelly accepted this but stated that there were nevertheless other options, including sites that may come onto the market in the future. The costs were likely to be around £300 million. Finance would come from a number of sources. Under any scenario, a presence would be maintained on the City Road site. Future plans would be subject to consultation with patients and health overview and scrutiny committees. Engagement would be led by the Clinical Commissioning Groups (CCGs), who had specific responsibility to engage. It was possible that there might be some double running of services when the new buildings opened.

The Committee expressed its support for the proposals. It noted that the hospital was a foundation trust and was therefore able to finance the re-location without external involvement, although the plans would need to be acceptable to Monitor and the Treasury. UCL were the hospital's academic partner and would be contributing to the cost.

In answer to a question, Mr Pelly stated that the hospital was looking at where its patients came from and whether they could be dealt with at another site.

They had noted that 60% of patients being treated at the City Road site passed by another Moorfields facility on their way there. Work was required to persuade patients to go instead access other Moorfields facilities, where they could receive the same level of care.

The Committee emphasised the importance of effective engagement in order to secure full support for the plans. A location close to Kings Cross was likely to attract more foreign patients. In answer to a question, Mr Pelly reported that Moorfields were likely to both stay and expand their presence on the St Ann's site in Tottenham.

RESOLVED

That the Chief Executive of Moorfields Eye Hospital be requested to report further to the Committee on plans for the re-location of the hospital in due course.

6. ACCIDENT AND EMERGENCY (A&E)

The Committee considered A&E performance statistics within acute hospitals in north central London as follows:

Barnet & Chase Farm: Janet Mustoe, Dr Tim Peachey and Dr Bal Athwal, attended the meeting from Barnet and Chase Farm hospitals. They reported that the trust's figures covered two separate district general hospitals sites – Barnet and Chase Farm. The Barnet site was the slightly busier of the two. There had been challenge in improving performance in quarter 1. Post Acute Care Enablement and a Triage Elderly Assessment Team, which aimed to treat elderly people as quickly as possible, were being established on the Barnet site. At Chase Farm, around 40% of patients were now treated by GPs. A Rapid Improvement Plan, which was led by Enfield CCG Urgent Care Board, was in place.

In answer to a question, the Panel noted that there was no hard evidence of patients being misdirected to A&E following consultation with the 111 Service. However, it would be possible to obtain relevant data on referrals from the 111 Service. It was agreed that the Trust would liaise with the 111 Service and analyse referral data to confirm that patients were being referred to A&E appropriately by the 111 Service.

It was noted that there was some anecdotal evidence that patients preferred to attend A&E instead of visiting their GP. Information was passed to GPs on contact between their patients and the 111 Service but this did not specify what happened next as a result of the call. This meant that GPs were not getting a full picture of the situation. It was also noted that Barnet's performance for time to initial assessment was better than some hospitals that had Urgent Care Centres.

In answer to a question, it was noted that Enfield Council was working with the Trust and NHS community services to improve care for older people and had

provided £2 million of funding to facilitate this. In particular, elderly people were now dealt with at the “front door”. The Trust had also prioritised actions that made the most impact in treating them.

Dr Peachey reported that disaggregated data was available for each of the two sites that the Trust was responsible for but aggregate data for both sites was required to be published. There were currently challenges in maintaining performance on the Barnet site due to ongoing building work.

North Middlesex University Hospital: David Donegan and Julie Lowe attended the meeting from the North Middlesex Hospital. They reported that the hospital dealt mainly with patients from Enfield and Haringey. A&E operated out of a single site. Additional funding was being invested in it, including the employment of additional doctors. The Trust was part of Haringey Urgent Care Board. Time to decision was currently improving and the Trust was happy with present performance.

Ms Lowe reported that the improvements to the hospital that had been introduced as a result of the Barnet, Enfield and Haringey Clinical Strategy had made it a more attractive option to A&E consultants and it was becoming less difficult to recruit. A large percentage of patients used the Urgent Care Centre and there was a need to make sure A&E was used appropriately. Priority was given to blue light calls but the department was big enough to cope with some demand from patients who could be treated elsewhere. Demand for A&E was currently static but was expected to increase. This had been planned for though and therefore could be accommodated.

Mr Donegan reported that total time in A&E was currently less than 4 hours for 98/99% of Urgent Care Centre patients. Admission avoidance was nevertheless important. The key issue driving the trust’s performance challenge was delayed discharges into the community and differences between local authority approaches. The Trust worked closely with partners, including adult social care, to address this. Teleconferencing with GPs was being used and it was planned to expand this.

In terms of referrals from the 111 service, there was no specific information that the trust currently held other than anecdotal.

Royal Free: Dr Steve Shaw and Kate Slemeck attended the meeting from the Royal Free. There had been a presumed impact from the new 111 service but that service now seemed to be “bedding in”. The Trust had now been compliant with waiting time standards for 23 consecutive weeks.

Committee Members commented on the fact that the average for total time in A&E had been 239 minutes for all three of the periods quoted in the statistics. The Trust acknowledged the fact the figures might appear questionable and agreed to check them and report back. Aside from these figures, Committee Members felt that the statistics were good.

The Trust reported that urgent care was an integral part of their A&E. The performance of A&E was reflective of that of whole hospital. Senior presence in A&E was particularly important.

Committee Members commented that, despite there being an urgent care centre on site, patients had to wait longer to be seen initially at the Royal Free than other hospitals but that the time that it took for a decision to be taken regarding treatment was significantly better. The Trust stated that this was due to the hospital using a different approach to patients than other trusts.

In terms of the affects of the 111 service, the Trust was of the view that this had now settled down. Camden and Islington CCGs were doing some work on this area through urgent care boards.

University College London (UCL): Dr Jonathan Fielden and Dr Daniel Wallis attended the meeting from UCL. The A&E service had been under pressure, as indicated by the statistics. In particular, the Emergency Department was in the middle of a 3 year rebuild to accommodate current and future pressures. There had been a significant growth in attendances but this had not been translated into a proportionate increase in admissions. The percentage of patients that could have been seen in primary care was relatively unchanged at around 8%. The local population was changeable. It was known that if they went to A&E at UCL, they could be seen very quickly by world class clinicians. Evidence suggested that it tended to be young people (18-45) who were inclined to prefer attending A&E to visiting their GP for a consultation. Patients also came from a wide area across all of London, perhaps due to the convenience of access of UCLH, including some who attended on their way to work. There was concern at the continuing increases in attendance and work was being undertaken to facilitate a cultural shift, although to date no one had managed to achieve this at large scale.

Committee Members highlighted the fact that the figure of 8% for patients that could have been treated instead in primary care differed from other figures that had been given by NHS bodies, which ranged from 15% to 40%. The Trust responded that it was difficult to be exact. The criteria that had been used for their statistics was patients that were seen and did not require any further investigation. There were probably other categories of patients that could also be treated effectively in a primary care setting

Committee Members drew attention to the apparently high figures for the length of time to initial assessment. The Trust reported that there was partly an issue with the quality of data and that this had arisen due to IT problems. The current median was 12 minutes and 60% of patients were seen within 15 minutes. It was very rare for there to be a significant ambulance queue as ambulance handover statistics showed. There were also problems with the time to treatment figure. The Trust understood concerns about the figures, particular in respect to the most recent quarter. However, the Trust had met the necessary standards for 2012/13 and for quarters 1 and 2 of 2013/14. Although there had been an increase in the number of attendances, these had generally been for

minor illnesses and injury. They were not aware of any tangible increase in the number of inappropriate attendances due to the introduction of the 111 service.

Whittington: Carol Gillen attended the meeting from the Whittington Hospital. She reported that the time to treatment had proven to be the biggest area of challenge and the focus was currently on improving the statistics for this. Quarter 1 had been particularly challenging, with an extended winter season. As part of ongoing work, the Emergency Department was reviewing its staffing levels and skills mix. The Trust had received NHS winter pressures funding. It was working with partners in Haringey to provide a rapid response to vulnerable patients. This involved joint work being undertaken with district nurses and social workers.

There had been a surge in attendances earlier in the year but this had now subsided. A snapshot of activity had been undertaken in September for Camden and Islington Urgent Care Boards and it was agreed that this would be shared with JHOSC Members.

Committee Members commented that the unplanned re-attendance rate was very low. The Trust responded that this was due to close working with community health services and social care. A whole systems approach was followed and this had led to real improvements, especially in Haringey. Good practice was shared informally, through Urgent Care Boards and UCL partners. In Islington, integrated working was being progressed with shared posts and budgets.

RESOLVED

1. That Barnet and Chase Farm hospitals be requested to liaise with the 111 Service to provide details of referrals and whether patients are being referred to A&E appropriately by the 111 Service;
2. That the Royal Free be requested to confirm the validity of their data in respect of total time in A&E; and
3. That the Whittington be requested to share their snapshot of A&E activity with the Committee.

7. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY ROYAL FREE

Kim Fleming, from the Royal Free, reported on the potential acquisition by the Royal Free of Barnet and Chase Farm hospitals. The acquisition was intended to advance the clinical strategy of the health economy for the next five years. There were a number of challenges that needed to be addressed. There were likely to be marked changes in population. In particular, there was likely to be more older people, especially in outer London. There would also be changes to the NHS. Standards were rising and more care was consultant delivered. There was also likely to be a significant gap in funding by 2018-19. A final decision

would be made in the spring regarding the acquisition. This would be after the final decision on the implementation of the BEH Clinical Strategy.

The only changes that were envisaged to clinical services and their distribution between the hospitals that would be part of the trust should the acquisition go through would be to the most specialised services. Most of these had already been subject to change or were in the process of changing. It was recognised that the Royal Free Hospital had accessibility issues and it was therefore not intended to require patients currently treated elsewhere to go there instead. The benefits of the acquisition would arise from being better able to assist commissioners in achieving their objectives, economies of scale and better buying power.

Mr Fleming stated that the Royal Free would need to determine the achievability of savings from the acquisition in order to decide whether it was a viable proposition. No decision had been made as yet. The trust was aware of changes implicit in the BEH Clinical Strategy. They were also aware of the potential for surplus land on the Chase Farm site but had not made any decision about disposal or the ring fencing of receipts.

The Committee noted that the potential transaction had not arisen from any financial challenge that the Royal Free might face. There were gains to be made from learning and there had been a number of meetings regarding specialities. The potential benefits to be gained from the acquisition had been looked at and the results so far were very positive. For example, there would be easier access to research trials for patients.

Committee Members commented that there was now only 7 weeks until the BEH Clinical Strategy went live and the acquisition would now mean the involvement of another hospital. It was unclear what the impact of this would be. It was felt that clarity was needed on exactly what was being proposed and the rationale behind it. Concern was also expressed at how the Committee had found out about the proposed changes. It was felt that there was not yet enough information available to form an opinion regarding the potential benefits. There was a need for the Committee to be apprised of the strategic factors influencing the decision. The Committee had been given the impression that there was little alternative for Barnet and Chase Farm hospitals than to go along with the acquisition.

Mr Fleming stated that the Trust was happy to respond and participate in dialogue. He was happy to come back to the Committee to discuss the issue in greater detail. It was up to the Royal Free board and Monitor to decide whether the acquisition should go ahead. The alternatives that might be available for Barnet and Chase Farm were a matter for their trust board to decide. Any delay in implementing the BEH Clinical Strategy could possibly have implications for the timetable for the acquisition. They also felt that the views of commissioners needed to be considered as part of this discussion.

Mr Fleming stated that the acquisition, if it went ahead, would likely to be completed in April, and therefore it might make sense to have such a discussion

ahead of this date. Overall the clinical benefits of the potential acquisition remained clear. However, there was some caution regarding financial issues.

RESOLVED

That a further detailed item regarding the acquisition of Barnet and Chase Farm hospitals by the Royal Free including the strategic factors influencing decision making and the potential implications be considered by the Committee at an appropriate time and that this include specific input from commissioners.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS

The Chair reported that this item had been deferred until the next meeting as the case for change had not yet been agreed by NHS England.

9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - UPDATE

Julie Lowe, Chief Executive of North Middlesex University Hospital and Siobhan Harrington, Programme Director, BEH Clinical Strategy reported on progress with the implementation of the strategy. The overall aim of the strategy was to provide safer, high quality care. A joint meeting of the CCGs of Barnet, Enfield and Haringey in September had agreed to the changes proceeding this winter. The two acute trusts had previously confirmed that they were ready to implement the changes.

It was considered that undue delay could jeopardise patient safety. On 20 November, the labour ward at Chase Farm would close whilst on 9 December, A&E would close to ambulances from 3am, with the Urgent Care Centre opening at 9am. However, the vast majority of patients who were currently using A&E would still be able to receive their treatment at Chase Farm Urgent Care Centre. Recruitment for additional posts at the North Middlesex Hospital was going well. In particular, the Trust has successfully recruited A&E consultants.

Committee Members questioned whether a merger between Barnet and Chase Farm and the North Middlesex Hospital (NMUH) might be more appropriate. Barnet and Chase Farm hospitals were viewed as not being viable financially as stand alone foundation trusts whereas the NMUH was considered to be on its journey to Foundation Trust. It was noted that had been a feasibility study conducted some time ago considering the potential viability of a merger of Chase Farm and NMUH which concluded that this was not a viable option for Foundation Trust.

Committee members expressed concerns that the acquisition of Barnet and Chase Farm by the Royal Free could lead to changes to the Clinical Strategy, but Ms Harrington confirmed that the Royal Free was committed to implementing the Strategy in full.

Ms Lowe reported that the National Trust Development Agency was responsible for determining the long term future of Barnet and Chase Farm hospitals and

NMUH as they were both currently not foundation trusts. NMUH currently had little involvement with the Barnet site of Barnet and Chase Farm hospitals.

Committee representatives from Enfield stated that their position was already well known and that it was the Council's decision to seek judicial review of the decision to implement the strategy. Ms Harrington stated that she was disappointed by the Council's decision. There were significant concerns at the possible impact on patient safety if the action by the Council led to delays in implementing the strategy. There was commitment from the CCGs and the acute trusts to progress the implementation of the strategy to the planned timescale.

10. MEETING OF MEMBERS FROM BARNET, ENFIELD AND HARINGEY TO CONSIDER ISSUES RELATING TO BEH MHT

Rod Wells and Dave King, from Haringey Needs St Ann's Hospital, addressed the meeting regarding concerns about mental health provision on the St Ann's N15 site. The number of mental health beds on the site had been reduced in recent years from 50 to 35 and they were of the view that expanded mental health provision on the site needed to be provided as part of its redevelopment as current capacity was inadequate. In addition, they felt that there needed to be an integrated child care centre within the plans. They felt that the Committee needed to look closely at mental health services and, in particular, should re-visit the issue of the response by Barnet, Enfield and Haringey Mental Health Trust to the recent CQC reports at an early stage.

Committee Members stated that mental health trusts were facing continuing increases in demand for their services whilst their funding was being reduced every year. There were also differences in the funding levels provided for each of the three boroughs that the Mental Health Trust covered.

RESOLVED:

That health scrutiny committees within Barnet, Enfield and Haringey be updated in three months time on progress achieved by Barnet, Enfield and Haringey Mental Health Trust in responding to issues raised by the Care Quality Commission in recent inspections of services.

12. FORWARD WORK PROGRAMME

The Committee noted that NHS England were ultimately responsible for the allocation of GP funding and requested that an item be placed on a future agenda on this issue.

RESOLVED:

That the issue of GP funding be added to the work plan for future meetings.

Gideon Bull
Chair

Meeting finished at 13:15